deschutes dermatology
MEDICAL AESTHETIC

PATIENT REGISTRATION

PATIENT INFORMATION Date Completed _____/_____/_____

Full name _____ Birth date _____ Age_____
Last First MI

Address _____ City/State _____ Zip_____

Assigned at Birth Sex ☐ Male ☐ Female Gender Orientation ☐ Male ☐ Female ☐ Other

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Daytime Phone _____ OK to leave voice message? **PLEASE INITIAL** YES_____ NO_____

Cell Phone _____ OK to leave text/voice message? **PLEASE INITIAL** YES_____ NO_____

Work Phone _____ OK to leave voice message? **PLEASE INITIAL** YES_____ NO_____

Email Address _____ ☐ Opt-out for Cosmetic Specials
Email address used for appointment reminders / Patient Contact and Information / Cosmetic specials

Pharmacy _____ **Primary Care Physician** _____

Employer _____ Occupation _____

SPOUSE or **PARENT** (if patient is a minor)
Full Name _____ Birth date _____
Last First MI

SS# _____ Employer _____ Work Phone _____

Address ☐ Same as above _____City/State_____ Zip _____
I give permission to discuss my medical condition with this person ☐ **Yes** ☐ **No**

WHO MAY WE CONTACT IF WE CAN'T REACH YOU:

Full Name _____ Daytime Phone _____
Last First MI

Relationship to patient _____
Address _____ City/State _____ Zip _____
I give permission to discuss my medical condition with this person ☐ **Yes** ☐ **No**

AI Documentation Notice:
During your visit, your provider may use secure artificial intelligence (AI) technology to assist with documenting your medical record. This technology is used solely to improve the accuracy and efficiency of clinical documentation. Your provider reviews, edits as needed, and approves all documentation before it becomes part of your medical record.

- I have read and understand the Financial Policy. I have been provided a copy for my personal records.
- I authorize the taking of photographs to document my medical condition.
- I authorize Deschutes Dermatology to obtain information on my prescription(s) from SureScripts to conduct electronic prescribing.

SIGNATURE _____ **DATE**_____